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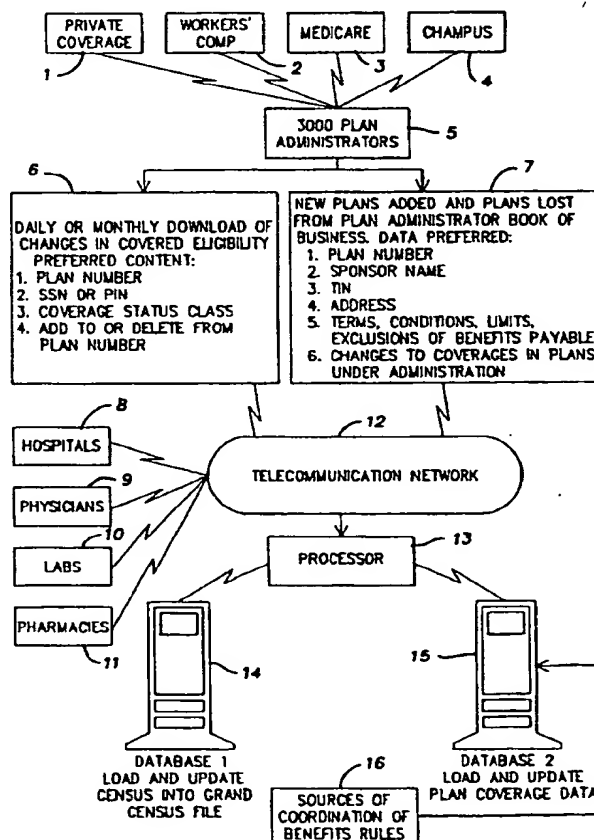
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(54) Title: SYSTEM FOR MEDICAL BENEFITS CLEARINGHOUSE

(57) Abstract

A method for operating a computer apparatus for applying the rules for coordination of benefits to claims under medical insurance. The computer has a first database containing a grand census file identifying all individuals by social security number of personal identification number together with the plans under which they are covered. A second database contains information as to the nature of the plan coverage together with the rules for coordination of benefits. When a claim is processed, it is first checked against the individual by identification number in the first database to determine all plans under which coverage could be obtained. Thereafter, the claim is processed for coverage under the information in the second database together with the rules for coordination of benefits to determine primary and secondary coverage. Optionally, the claims may then be processed for payment according to such primary and secondary coverage. All such determinations are then stored in a historical database for future reference.



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1                    SYSTEM FOR MEDICAL BENEFITS CLEARINGHOUSE2                    BACKGROUND AND SUMMARY OF THE INVENTION

3            The present invention pertains to a method for data  
4 processing, and more particularly to the evaluation of primary  
5 and secondary liability among multiple sources and types of  
6 medical insurance and benefit plans (a clearinghouse). The  
7 method enables automated submission of claims to the source  
8 of insurance or benefit coverage which is legally the primary  
9 obligor of the medical claim at issue for payment for medical  
10 services rendered. This process may involve computer  
11 comparison and processing of diverse schedules of benefits and  
12 terms of coverage.

13           The method includes loading into a central database a  
14 list of coverage plans preferably by plan number, a list of  
15 sponsors of those plans preferably by employer or tax  
16 identification number, including the nature and extent of  
17 benefits payable under the plans, and a list of all the  
18 covered persons under those plans, preferably by social  
19 security number (SSN) or a personal identification number  
20 (PIN), hereinafter referred to as identification codes, and  
21 by the class of coverage which each such person has under each  
22 plan. Various other sources and patterns of data are possible  
23 under this method.

24           The method then receives inquiries regarding a claim  
25 wherein a given social security number or other identifying  
26 code represents the person for whom care was or is about to  
27 be rendered. The present invention automatically identifies  
28 all sources of insurance coverage for the person identified  
29 by that identification code, then applies federal, state, and  
30 private rules of coordination among benefit plans to identify  
31 the primary and secondary coverages.

32           Medical billing offices may be supplied with the name, address  
33 and plan number of the primary coverage payor or of a  
34 hierarchy of primary, secondary, tertiary, etc., payors.

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1 Insurance claims processing offices may then be provided with  
2 notice by the clearinghouse as to whether they are the primary  
3 or secondary payor on a given claim.

4 Depending on hardware used, an embodiment of the present  
5 invention would allow capture of all the elements of a  
6 complete medical bill, including the patient signature.  
7 Electronic downloading of claims and proof of care for a given  
8 calendar day may be processed through the clearinghouse to the  
9 primary and secondary payors at close of business or other  
10 predetermined time.

11 This invention is significantly different from the  
12 invention described in U.S. Patent Number 4,491,725. That  
13 patent issued for an encoded identification card which allowed  
14 medical providers to bill their service by modem. The central  
15 process of the '725 patent is the translation of medical  
16 billing codes into coverage codes under the patient's  
17 insurance plan, and the electronic transfer of funds from the  
18 insurance plan to the medical care provider. Patent 4,491,725  
19 did not contemplate the possibility of multiple sources of  
20 coverage for any given individual, a phenomenon which exists  
21 in many households today. It makes no assertion of an ability  
22 to coordinate benefits among plans that cover the same person.

23 Most Americans are covered today under health insurance  
24 of one kind or another, including coverage from over 900  
25 insurance companies, and approximately 2,500 claims  
26 administrators. These parties process claims for public and  
27 private employee benefit plans, and public welfare programs  
28 including Worker's Compensation plans, Medicare, Medicaid,  
29 Titles IV, V, and VI, plans for coverage for retired public  
30 and private sector employees, plans for the coverage of  
31 civilian relatives of military employees (eg: CHAMPUS),  
32 supplementary coverage plans, homeowners, casualty insurance,  
33 employers, unions, fraternal, social and religious  
34 organizations, the Indian Health Service, the Veteran Affairs  
35 Health Programs. Further, the patient himself is often liable  
36 for all or part of many medical bills, and that liability may

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1 be subject to amounts deductible from his general coverage  
2 under any of the foregoing insurance programs.

3 The typical procedure for billing medical services  
4 involves an electronic billing process for 80% of Medicare  
5 claims, and payment by invoice by virtually all other plans  
6 (the vast majority of paid claims). Ordinarily, a medical  
7 bill is prepared on paper and mailed to the insurance carrier,  
8 claims administrator, or other party indicated by the patient  
9 to be the source of his medical insurance coverage.

10 Frequently, patients err in their statements of coverage,  
11 or are unaware of multiple sources of coverage available to  
12 them, or have no clear understanding of which of the coverages  
13 available to them is, at law, the primary source to pay a  
14 given medical bill. For various reasons a subrogation  
15 interest to another source of coverage exists for the carrier  
16 or claims administrator initially billed for approximately 15-  
17 25% of all claims filed in the United States. The result of  
18 not naming the correct primary insurance coverage provider is  
19 a substantial increase in operating costs for medical care  
20 providers and insurance carriers and administrators, and  
21 substantial delays in payment of claims, resulting in  
22 increased capital costs for medical care generally.

23 In addition, many persons are covered by more than one  
24 plan of coverage and fail to disclose this information to  
25 either their medical care provider or their insurance carrier  
26 or claims administrator.

27 Claims payors typically have no general source of  
28 coverage information for their covered persons other than  
29 information volunteered by the covered person, and cannot,  
30 prior to the present invention, systematically capture  
31 information that would allow full subrogation of claims to  
32 which they are secondary payors. The results of this lack of  
33 information are a large displacement of claims costs to payors  
34 of coverage who have a only a subordinate liability to pay for  
35 care, and often more than one payor paying an entire claim  
36 resulting in the payee being unjustly enriched.

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1           Many Americans travel across state lines to work, and  
2 have coverage in two or more states, subject to differing  
3 state insurance regulations, including coordination of  
4 benefits (COB) and subrogation regulations. In addition, many  
5 persons have coverage that is administered in a remote, rather  
6 than in their own or a contiguous state, or may have coverage  
7 under an ERISA-regulated plan that may have adopted non-  
8 standard rules for the coordination of benefits. ERISA-based  
9 plans are not regulated on the rules of coordination in most  
10 states, and thus represent a high-volume challenge to maintain  
11 up-to-date COB rules in any coordination system.

12           Many different classes of coverage exist, for example,  
13 regular health insurance, and supplemental insurance which  
14 covers the otherwise uninsured risk of the insured person.  
15 Current rules of coordination allow for various levels of  
16 exactitude in assessing the sources of contribution on any  
17 given claim, and the instant invention has the capacity to  
18 respond with several different levels of precision with  
19 respect to the coordination issue in any given fact situation.  
20 Optimal coordination in the context of differing classes of  
21 insurance requires coordination on the basis of the medical  
22 service rendered. For example, where a standard commercial  
23 health insurance plan may omit coverage for vision services,  
24 a supplemental vision policy may cover these bills, and to be  
25 complete, the COB test would preferably include a  
26 specification of the service rendered as compared to the  
27 services covered under each plan covering a given individual.  
28 Thus, where no detail is available, the instant process will  
29 identify all sources of insurance. Where no coordination  
30 regulations among multiple possible obligors, a significant  
31 non-obvious utility of the instant invention is the service  
32 of notice to the multiple primary obligors that the others  
33 exist, opening a context for voluntary coordination or  
34 segregation, or contribution to the patient of the  
35 clearinghouse. Where sufficient detail as to a claim exists,  
36 a fully detailed and dispositive assessment of the hierarchy

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1 of obligors and the amounts of their respective and collective  
2 obligations can be made.

3 Thus, the development of a process that can economically  
4 provide a comprehensive test of the priority of obligation has  
5 been obstructed in the past by a number of forces. These  
6 include the high rate of change in enrollment in any of the  
7 aforementioned insurance programs (estimated at 5-7 Million  
8 enrollment changes per month) and the sheer complexity of the  
9 possible sources any individual may have for coverage or  
10 indemnity.

11 There is another layer of complexity that has forestalled  
12 development of a clearinghouse of this class, which is the  
13 internal management of a given employer, pension, or public  
14 benefit plan, and/or a change of vendors which changes the  
15 terms of eligibility, benefit schedules, or operating rules,  
16 which in turn may affect the outcome of coordination results  
17 as between such a plan and other sources of coverage for the  
18 individual. Thus, a public retirement health benefit may at  
19 some point in time eliminate vision coverage, resulting in a  
20 finding by the clearinghouse that the patient's supplementary  
21 coverage is, in fact primary, when in the prior month the  
22 retirement plan would have been primary. The optimal  
23 execution of automated coordination therefore requires up-to-  
24 date tracking of the content of benefit plans, as well as  
25 accurate dating of medical services billed.

26 The interactive regular (preferably daily) online update  
27 of this data is important and represents a large-volume  
28 regular transaction and a large-volume of record keeping.  
29 However, this process allows the instant invention to permit  
30 the same degree of freedom of contract, and the same degree  
31 of innovation in the large and complex market for health  
32 insurance.

33 Thus, the patterning of tests within a software program,  
34 the purpose of which is to provide a comprehensive test of  
35 coordination of benefits, is a project of enormous complexity,  
36 with thousands of possible outcomes for an individual claim.

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1           Use of the invention here described would also in no way  
2   restrict evolution and development in the insurance industry,  
3   in the management of individual plans, in the development of  
4   new state or federal formulae for the coordination of benefit  
5   plans or the financial contribution of various organizations  
6   on given medical bills, and would not require, but could adapt  
7   to, modifications in federal regulation on this subject  
8   matter, as the model here at issue is adaptable to changing  
9   coordination rules and rules affecting coordination.

10          Until the present time the common supposition has been  
11   that an insurmountable barrier to automated COB existed in the  
12   variety of hardware and software choices used by medical  
13   providers and insurance administrators in their work.  
14   Heretofore, the presumption has been that a national or  
15   international standard for electronic communication of benefit  
16   documents was necessary to attempt automated COB or electronic  
17   billing. This presumption is incorrect. Contemporary  
18   technology allows for the translation of differing operating  
19   systems and software programs into other such formats without  
20   significant modification of either system or program, and  
21   makes the otherwise prohibitive cost of retooling the billing  
22   and claims systems in a national economy unnecessary.

23          One example of the means by which this complex pattern  
24   of coverages and varying coordination rules can lead to  
25   willful abuse of the providers of coverage would be the case  
26   of a Medicare-covered person who also has employer-provided  
27   private insurance, insurance as a dependent on a spouse's out-  
28   of-state employer-provided private insurance, supplemental  
29   insurance, and workers compensation coverage. Such a person,  
30   suffering an accident injury, may, under the current method,  
31   file claims against all five plans and receive indemnification  
32   from all of them. Various authorities have estimated the 1991  
33   cost of fraud, error, and manhours consumed in efforts to  
34   correctly coordinate benefits as being between \$63,000,000,000  
35   and \$90,000,000,000.



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1       The invention here described would, under the current  
2 rules of coordination, excuse Medicare and the spouse's  
3 employer-provided insurance as secondary coverages, and would  
4 introduce the patient's primary (employment) coverage to the  
5 supplemental carrier an/or the workers' compensation provider  
6 for resolution of contribution formulae or the system would  
7 identify the correct primary obligor by application of rules  
8 of coordination of benefits. The instant invention may use  
9 diagnostic coding to gain an indication of the most probable  
10 obligor as between the employment and workers' compensation  
11 insurance. All of these tests may be implemented at the time  
12 medical service was rendered and/or at the time any or all of  
13 the above-listed sources of coverage processed claims from the  
14 injury at issue. No significant time would elapse before this  
15 coordination process was complete, and little or no human  
16 effort would be expended to capture and delete these multiple  
17 payments.

18       The solution of these related problems requires that  
19 participating sources of insurance coverage or medical  
20 benefits deposit data or make data accessible to a  
21 clearinghouse, preferably including:

22       a) the social security number and/or other identifying  
23 code of each person having a right to benefits under any plan  
24 operated by the insurance carriers or claims administrator;

25       b) the effective date of coverage and termination under  
26 the coverage at issue;

27       c) the plan number(s) under which such person is  
28 covered;

29       d) the nature of the coverage, its terms and  
30 limitations, the benefits payable, as a subfile of each such  
31 plan number;

32       e) the class of coverage under which each individual is  
33 covered (e.g.: employee, spouse, child, retiree. . .); and

34       f) mailing, tax identification, and other control data  
35 for the plan of coverage and its center(s) for claims  
36 administration. Because of turnover in persons covered under

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1 any given plan or method of coverage, this data should be  
2 updated frequently, for example, daily.

3 The present invention would allow the claims processor  
4 to make an automated or telephonic inquiry on the social  
5 security number or other identifying inquiry on the social  
6 security number or other identifying code of the person at  
7 issue, and to determine from a computerized database of the  
8 clearinghouse that the applicant has coverage as an employee  
9 from another carrier or claims administrator. The carrier or  
10 administrator making the inquiry may be advised,  
11 electronically or telephonically, that it was secondary to the  
12 employer plan, and ought not to pay on the claim at issue  
13 without evidence of the primary payor's processing and  
14 payment.

15 The present invention thus eliminates to a great extent  
16 the need for human effort in coordination of benefits, beyond  
17 the establishment of a data link between the claims processing  
18 office computer systems and those of the clearinghouse. The  
19 present invention would establish to a high degree of  
20 reliability, primary and secondary liability, thus  
21 transferring claims to appropriate payors, and capturing both  
22 erroneous and intentional double billings.

23 By extending access to the clearinghouse to medical care  
24 providers, the care provider may identify primary and  
25 secondary payors by data link or telephonically. The result  
26 of this access and report would be the elimination of errors  
27 in routing accounts receivable, and the elimination of  
28 manhours in efforts to identify correct sources of primary  
29 coverage. Providers may include physicians, hospitals,  
30 pharmacies, laboratories, or other person or entities licensed  
31 or otherwise authorized under applicable state or territory  
32 laws to furnish healthcare items or services.

33 In a medical care venue, the present invention can  
34 establish sources of insurance coverage before admission or  
35 delivery of care services, and provides a means to capture:

36 a) diagnosis code;

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- 1                   b) date of service rendered
- 2                   c) care code;
- 3                   d) patient signature;
- 4                   e) payee employer identification number and mailing
- 5 information; and
- 6                   f) various control codes.

7           The unique method of the present invention can also  
8 electronically or on hard copy deliver accounts payable to the  
9 correct primary payor, eliminating a significant cost of doing  
10 business for medical care providers and insurers alike in the  
11 processing, mailing, and maintenance of paper records.

12          A significant non-obvious utility of a process such as  
13 the instant invention is the possibility of an large system  
14 of electronic commerce with one step and only one step, and  
15 little or no human effort to resolve the issue of primacy in  
16 obligation to pay for claims. The utility of this invention  
17 is in part in that it reduces the cost, time, and error rate  
18 of electronic billing systems by a very large factor insofar  
19 as so reduces the processing required to arrive at a correct  
20 hierarchy of payors.

21          Technology exists to capture patient signatures. For  
22 example, incorporating an electronic clipboard manufactured  
23 by Tappon Moore, Ltd. (or equivalent), would constitute a  
24 significant improvement in the security system of medical  
25 payment for a high percentage of care services rendered. At  
26 present, the majority of medical service bills are generated  
27 and paid without the patient's signature to certify that the  
28 care has, in fact, been rendered. The absence of proof that  
29 medical services were actually rendered has collateral impact  
30 in the abuse and manipulation of various benefit plans, as  
31 well as a diminution in the audit and cost containment efforts  
32 within the health care finance industry.

33                   BRIEF DESCRIPTION OF THE DRAWINGS

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1 FIG. 1 is an overall view of the method showing the  
2 various inputs through the telecommunication network to the  
3 processor;

4 FIGS. 2A, 2B and 2C are a flow chart showing the  
5 processing of claims through the method; and

6 FIG. 3 is a flow chart showing a method of processing  
7 claims for payment after the coordination of benefits has been  
8 applied to determine the primary and secondary sources of  
9 payment.

#### 10 DETAILED DESCRIPTION OF THE PREFERRED EMBODIMENT

11 Referring to FIG. 1 in greater detail, the method shows  
12 that a number of insurance programs such as private coverage  
13 1, Workers Compensation 2, Medicare 3 and Champus 4 by way of  
14 example, but not limitation, routinely deposit enrollment and  
15 plan change information to the plan administrators, although  
16 only four plan sponsors are shown, it is believed that in the  
17 current U.S. market there is approximately 2 million separate  
18 plan sponsors offering different plans and coverage to the  
19 entire U.S. population through 2,500 plan administrators in  
20 1994.

21 The plan administrators shown at 5 collect all the  
22 information and assemble their records and updates so that  
23 each maintains a current set of information as provided by the  
24 separate plan sponsors.

25 According to the present invention, there is a further  
26 download from the plan administrators 5 through a  
27 telecommunication network 12 to a central processor 13. This  
28 download takes two forms of which the first one indicated at  
29 6 should be done on a daily or monthly regular basis. This  
30 information should include the plan administrator's serial  
31 number for the plan coverage for each individual person and  
32 include that person's identification code together with the  
33 status or class of coverage under which the person is covered  
34 and the nature of the change from the previous information  
35 supplied for that person. The second download relates to

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1 plans deleted, new plans added and plans amended among each  
2 claims administrator's clientele and represents the data as  
3 to the general types of coverage of the plan including the  
4 plan number, the information as to the plan sponsors and any  
5 changes of any form to the existing plans or added plans.  
6 These downloads of data are separated and represented in the  
7 drawings as reposing in two databases solely for clarity.

8 The telecommunication network 12 may be of any type for  
9 transmitting data and is shown here in generalized form.  
10 Providers also have communication through the network 12 and  
11 may include such sources as hospitals 8, physicians 9,  
12 laboratories 10 and pharmacies 11 by way of example only, and  
13 these providers are the ones who are seeking payment from the  
14 payors whose information has been entered through the plan  
15 administrators 5.

16 The processor indicated at 13 is shown as being only a  
17 single processor but may in fact use distributed processing  
18 as an alternative. The processor 13 serves to link the  
19 systems together from the telecommunications network 12 to the  
20 databases 14 and 15 which store the information received  
21 through the downloads indicated at 6 and 7. The first  
22 database, Database 1 indicated at 14, contains a Grand Census  
23 File which is a complete statement for each individual as  
24 identified by Social Security Number or Personal  
25 Identification Number and the plan numbers under each such  
26 person as coverage for insurable claims and is preferably  
27 updated on a daily basis for any changes to the source of  
28 coverage or the list of covered persons. It is this central  
29 data base which utilizes the coordination of benefits rules,  
30 and without such a complete database, it is not possible to  
31 entirely eliminate or identify dual sources of coverage or  
32 payment.

33 Database 2, indicated at 15 contains the plan coverage  
34 data including updates as to the changes provided through the  
35 download indicated at 7 regarding plan coverage and  
36 conditions. Database 2 also serves as a source of storage for

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1 the coordination of benefits rules which may be updated as  
2 necessary depending upon changes in the law.

3 FIGS. 2A, 2B and 2C show in continuous form, the flow  
4 chart for a computer program utilizing the processor 13  
5 together with the databases 1 and 2 indicated at 14 and 15 in  
6 FIG. 1. The process inquiry server indicated at 19 in FIG.  
7 2A may be a portion of the processor 13 of FIG. 1. 17  
8 indicates all medical service providers which will query the  
9 method to learn the primary carrier for services rendered and  
10 these may be the hospitals, physicians, laboratories, etc. as  
11 indicated at 8-11 of FIG. 1. Also tied into the server 19 are  
12 all payors 18 who will be billed by the system for services  
13 provided by the providers of 17 and these payors 18 may  
14 include insurance companies, public health authorities and the  
15 like. Thus, all information goes into the server 19 and, in  
16 view of the generally universal access that may be had to  
17 server 19, it is highly desirable to provide certain forms of  
18 security. This security is first addressed at 20 to determine  
19 if the person is allowed access to the databases and the  
20 server to process the inquiry. If the inquiry is denied  
21 access, this decision is placed in storage for security  
22 investigation as indicated at 21 and operates to abort the  
23 inquiry as shown at 22 and report the error to the inquirer  
24 at 23 to see if possibly a wrong number has been entered. It  
25 will be understood that other forms of security may also be  
26 used including, requiring special modems to access the server  
27 as well as the use of data encryption in the inquiry to  
28 prevent unauthorized access, etc.

29 If the security operation clears the inquirer for the  
30 query, the next step is indicated at 24 is to test the  
31 patient's identification code to verify if it is in the  
32 database in order to process the inquiry. As shown at 25, if  
33 the answer is no, the result is stored for security  
34 investigation as indicated at 26 and the inquiry is aborted  
35 and the error is reported at 28 to the inquirer to see if  
36 possibly a wrong number has been entered. If the number is

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1 verified, then the query proceeds to database 1 as indicated  
2 at 29 to compare the social security or personal  
3 identification number to all plans of the database and all  
4 individuals entered therein. By checking this, the first step  
5 at 30 is to indicate if there is multiple coverage, that is,  
6 more than one source of coverage for a given social security  
7 number or personal identification number. If the answer is  
8 no, the plan information is reported to the inquirer at 31 for  
9 further options. This may involve reporting the invoice to  
10 the primary obligor 32 and this data is further saved in the  
11 database 33 to show that a claim has been made.

12 If there is multiple coverage, the plan terms are  
13 retrieved from Database 1 at 34. Then, as shown at 35, a  
14 determination is made as to whether the plan terms for each  
15 form of coverage exists. If the answer is no, the alternative  
16 is to determine primary coverage by class of coverage as  
17 indicated at 36 after which the name and other essential  
18 information of the primary obligor is reported to the inquirer  
19 37 and the invoice for the claim is remitted at 38 to the  
20 primary obligor and the query is saved in historical records  
21 database as indicated at 39. If the plan terms exist, then  
22 as shown at 40 the ICD 9 and CPT 4 codes (or DRG's or other  
23 methods of identifying care rendered) are matched to the coded  
24 benefits and coverage found in the plan terms located in  
25 Database 1 while certain ICD 9 codes are reported to public  
26 health authorities as shown at 41. As shown at decision box  
27 42, the question then is whether the ICD 9 and CPT 4 codes  
28 match more than one plan and according to that test if the  
29 answer is no, that is the codes match only a single plan, then  
30 the decision is made at 43 as to whether coverage is possible  
31 under this plan. If no coverage is possible under the plan,  
32 then a negative report on coverage finding is reported to the  
33 inquirer as shown 44 and the matter saved in the historical  
34 records database at 39.

35 On the other hand, if the codes match more than one plan  
36 then it is necessary to go to database 2 to retrieve the

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1 coordination of benefit rules, then according to these rules,  
2 if coverage is possible as determined at 43 then the  
3 coordination of benefit rules are applied to determine if  
4 there is multiple coverage to which the coordination of  
5 benefit rules are applicable as indicated at 48. If the  
6 answer is no, then a report of possible double coverage is  
7 made to the inquirer as shown at 49 and this information is  
8 saved in the historical records database at 39. If the  
9 multiple coverage is susceptible to the coordination of  
10 benefit rules and an affirmative action is obtained at 48,  
11 then the computer applies the coordination of benefit rules  
12 to the multiple sources to determine a hierarchy of legal  
13 obligation to indemnify or cover the claims as indicated at  
14 51. If the application of these rules indicates only a single  
15 coverage, the answer is no and the source of the coverage is  
16 reported to the inquirer as indicated at 54 and the  
17 information stored in the historical records database 39. If  
18 the answer is yes, then the coordination of benefit rules will  
19 rank the sources of coverage at 55 as primary, secondary,  
20 tertiary, etc. This entire ranking will be reported to the  
21 inquirer at 56 and the information stored in the historical  
22 records database 39 as indicated.

23 The foregoing description covers the method according to  
24 the present invention of determining primary, secondary and  
25 other liabilities among the payor as based on a central  
26 database of all insured persons. While it reports sources of  
27 coverage and ranking of the sources, it does not, in and of  
28 itself, provide for further processing of the claims, however,  
29 according to the present invention, a further processing of  
30 payment and coordination of benefits can be provided as shown  
31 in FIG. 3.

32 The processing of payable amounts and remittances starts  
33 with the finding of the primary carrier at 58 using the  
34 procedures as set forth in FIG. 2. Once the primary carrier  
35 is found, then it is necessary to recover the plan terms from  
36 database 2 as shown at 59 as well as retrieve from historical



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1 records the patient's account with the primary carrier  
2 including data such as paid deductibles, paid co-insurance and  
3 exhaustion of coverage limitations.

4 This information as passed on is indicated at 61 to allow  
5 the computer to apply an algorithm to adjust the claim item  
6 at issue in the inquiry against the plan coverages in the  
7 patient's account to determine the net obligation of the plan  
8 and the patient on the particular medical service being  
9 queried. After the primary obligation has been calculated at  
10 61, any remaining claim amount passes on at 62 to determine  
11 if there is any secondary coverage using a repetition of the  
12 processes in blocks 59, 60 and 61 to determine any amount  
13 payable under a secondary plan. Likewise, if any amount  
14 remains, it can be processed at 63 for tertiary, or any other  
15 ancillary sources of payment available under the coordination  
16 of benefits rules.

17 After the above has been calculated, the total amounts  
18 are tabulated at 64 and the computer then reports a statement  
19 of obligation to each payor 65 as well as a notice of billing  
20 to the medical service provider at 66. Optionally, a check  
21 or other form of remittance is prepared at 67 to the provider  
22 and a notice at 68 is sent to the patient of the billing  
23 amounts including any remaining amount due directly from the  
24 patient. The system periodically (daily) reduces tens or  
25 hundreds of thousands of transactions to a statement of net  
26 liability among the participating insurance and health care  
27 users thereof. Finally, all of the above transactions are  
28 recorded in historical records database 69.

29 It will be understood that while the above methods have  
30 been described as involving a single processor and two  
31 databases, but distributed processing can be used and  
32 databases can be separated in different locations although  
33 communication is necessary among all databases or with or  
34 through a central clearing point to allow the complete  
35 collection of information to allow the coordination of  
36 benefits process.

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I CLAIM: /

1           1.    A method for using a computer apparatus comprising  
2    a processing unit and a plurality of databases for rapidly  
3    determining the primary and secondary sources of health  
4    insurance coverage for any person having coverage from any  
5    source, public or private, said method comprising the  
6    following steps:  
7                storing in a database of said computer  
8    identification codes for each of said persons having health  
9    insurance coverage together with plan identification numbers  
10   for each such person under which such person has coverage and  
11   coverage data for each plan,  
12               storing in a database of said computer rules for the  
13   coordination of benefits,  
14               entering into said processing unit claims for  
15   payment under health insurance coverage,  
16               said processing unit accessing said database for  
17   relevant identification codes and plan numbers and relevant  
18   plan coverage data, and  
19               said processing unit thereafter accessing said  
20   database for the relevant coordination of benefits rules and  
21   applying said rules to determine primary and secondary sources  
22   of coverage.

1           2.    The method of claim 1 including the steps of  
2    periodically updating said identification codes for said  
3    persons in said first database.

1           3.    The method of claim 1 including the step of  
2    periodically updating said rules for the coordination of  
3    benefits in said second database.

1           4.    The method of claim 1 including the additional step  
2    of reporting primary coverage.

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1           5.    The method of claim 4 including the additional step  
2   of reporting secondary coverage.

1           6.    The method of claim 4 including the step of  
2   processing the financial obligation for payment.

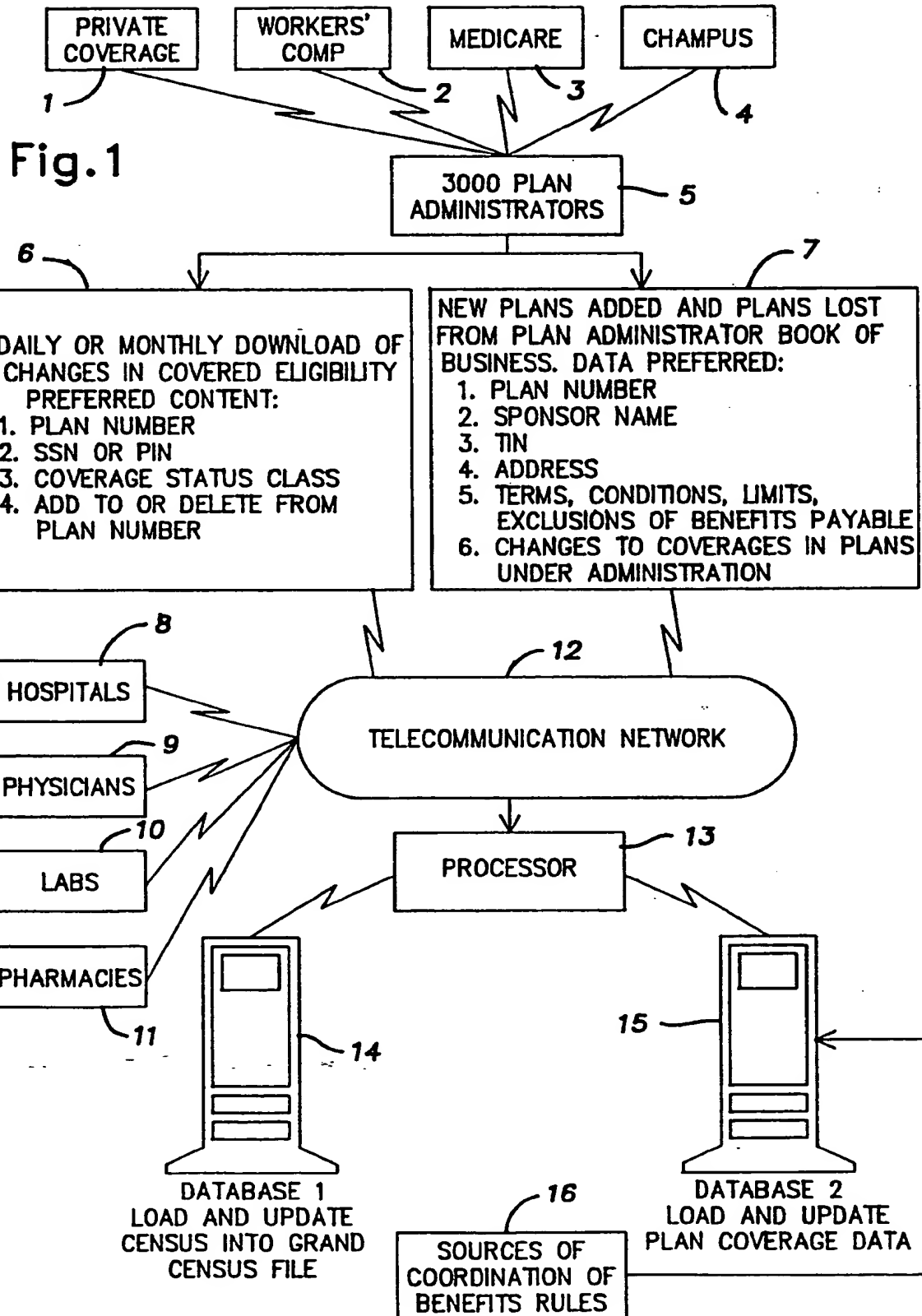
1           7.    The method of claim 5 including the step of  
2   processing the financial obligations of both said primary and  
3   said secondary obligors for payment.

1           8.    The method of claim 1 including the aggregation of  
2   information on financial obligations between and among users  
3   of the system.

1           9.    The method of claim 1 including the step of storing  
2   in the database the results of said determinations.

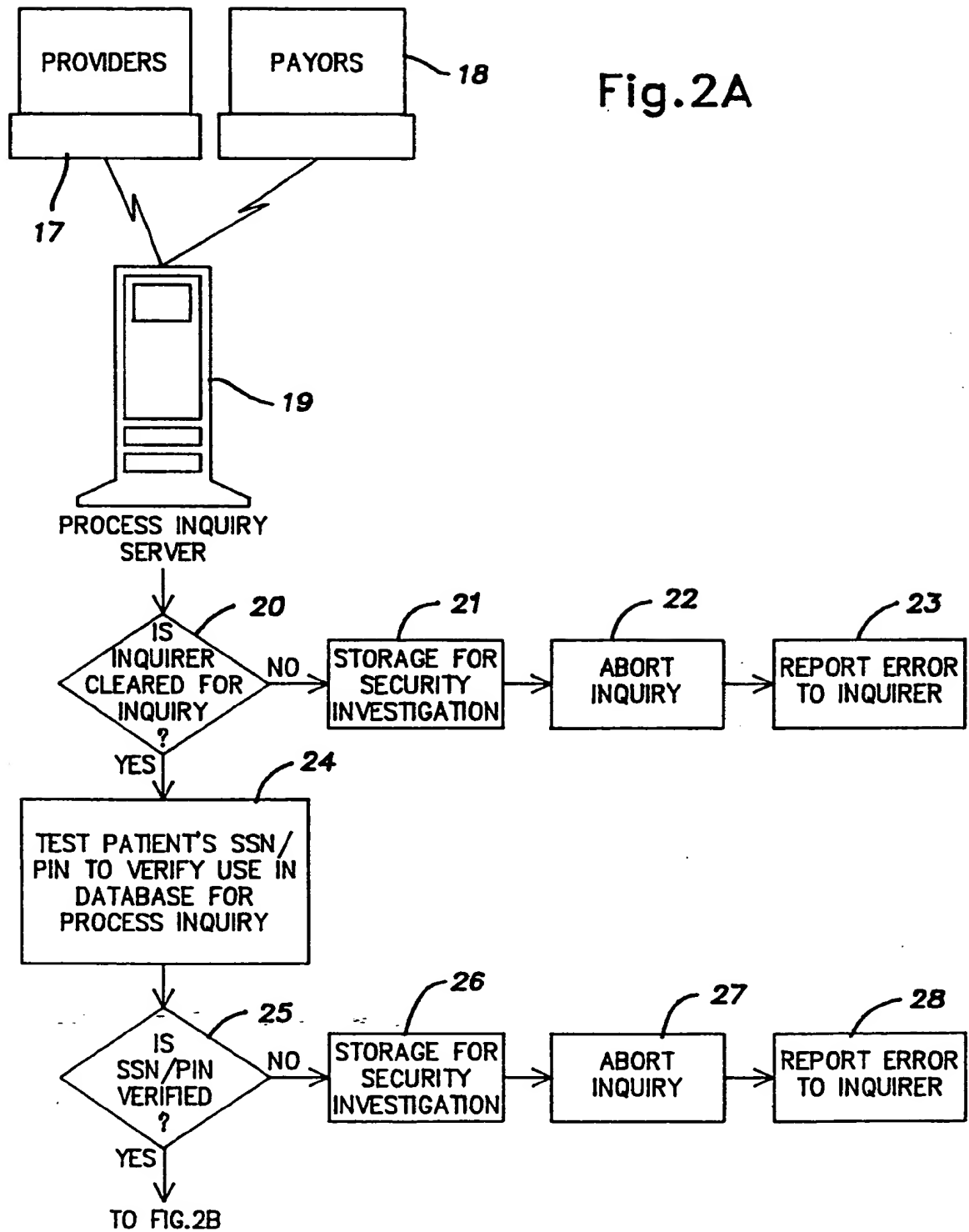
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Fig.2B

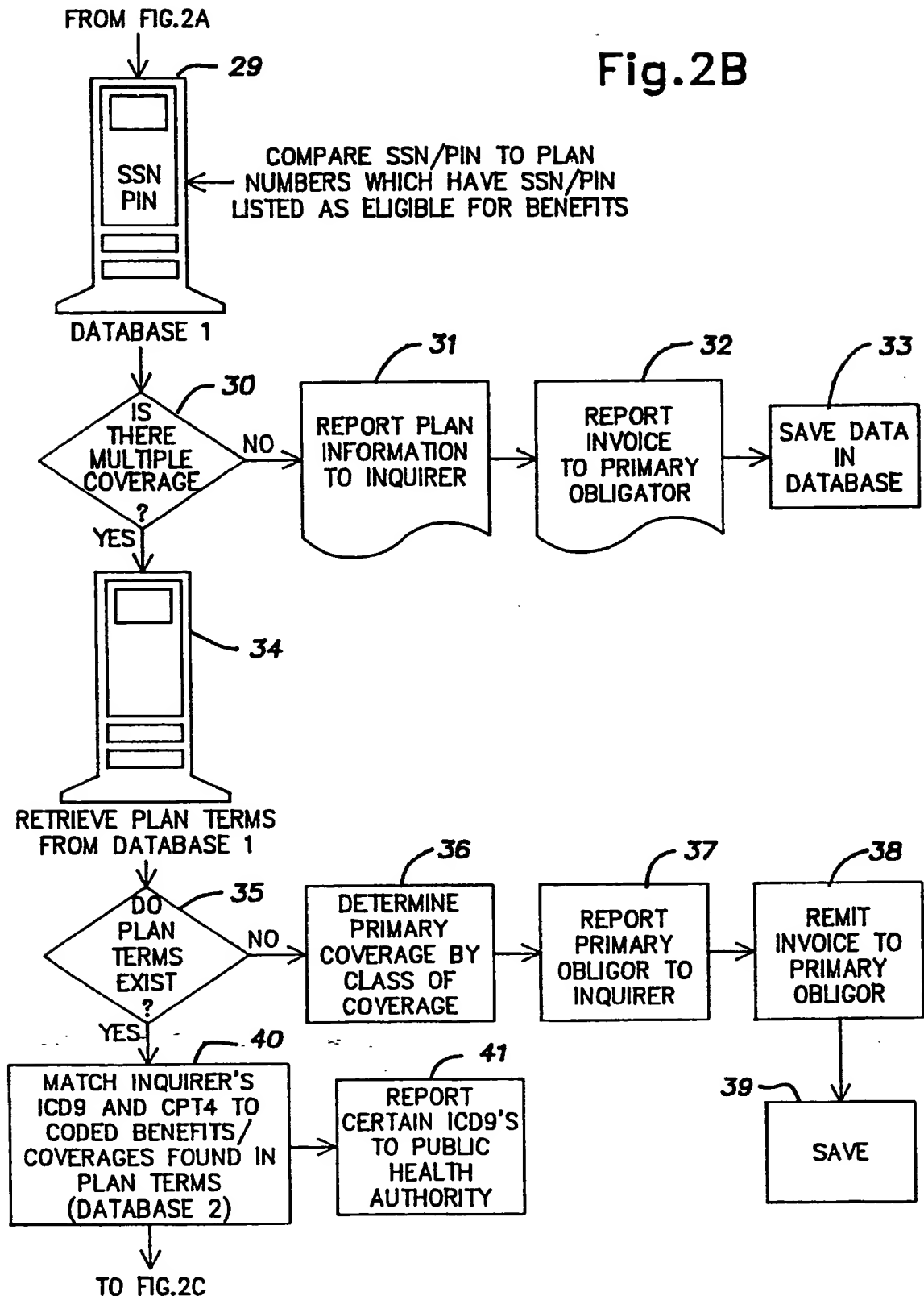
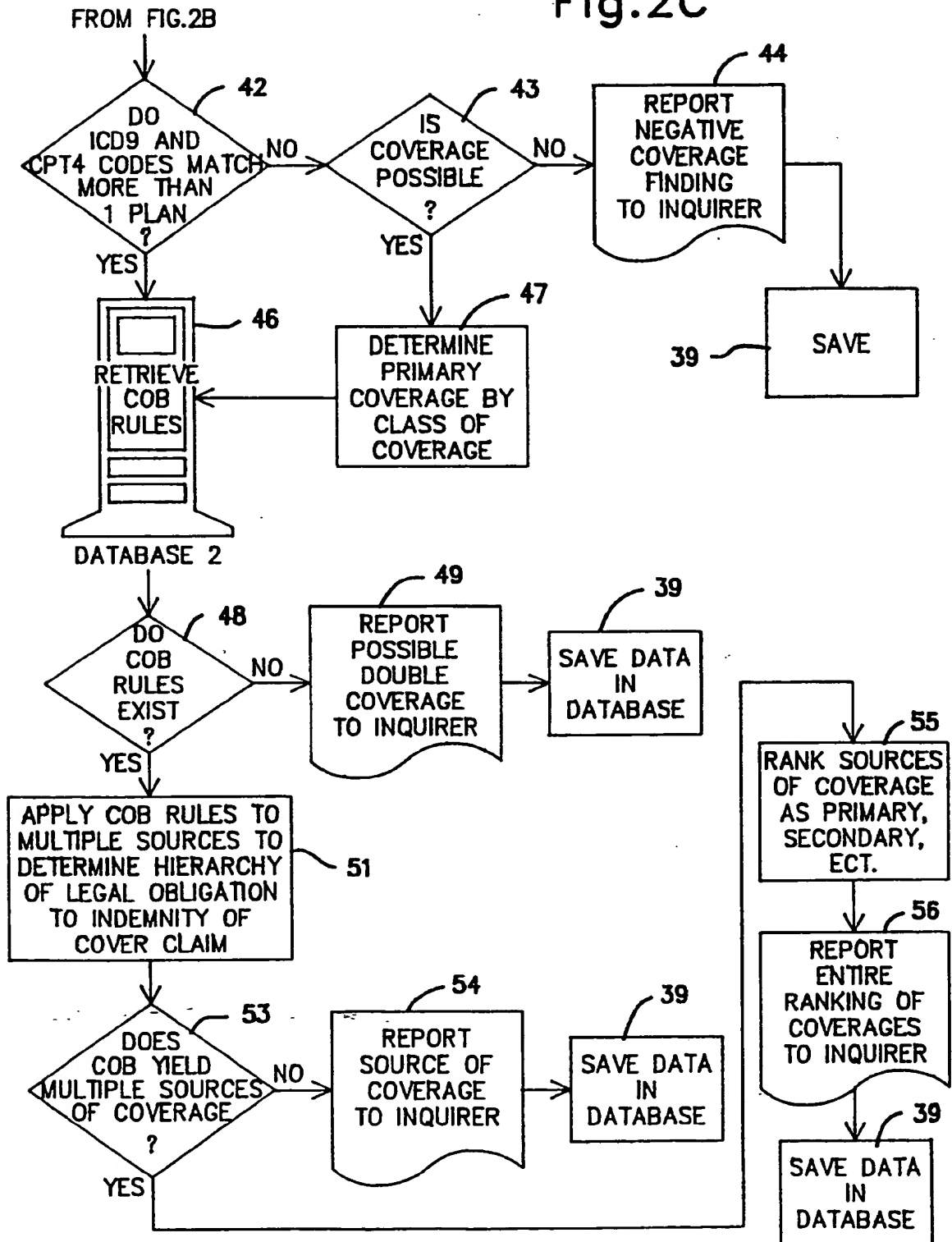


Fig.2C



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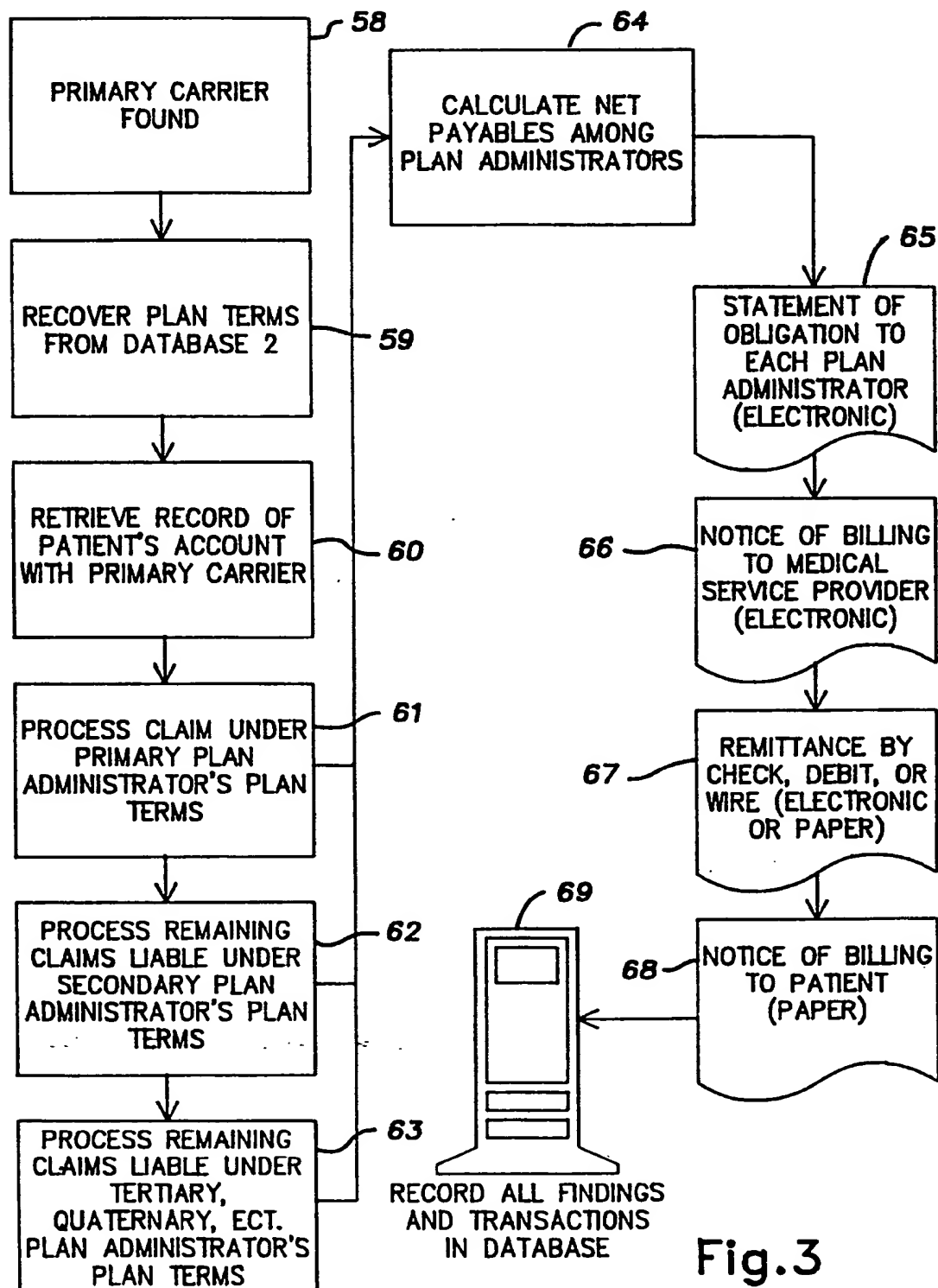


Fig.3